

Case Number:	CM15-0081681		
Date Assigned:	05/04/2015	Date of Injury:	02/22/2012
Decision Date:	09/04/2015	UR Denial Date:	04/01/2015
Priority:	Standard	Application Received:	04/28/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker was a 46 year old female, who sustained an industrial injury on February 22, 2012. The injured worker previously received the following treatments left shoulder surgery, Fenoprofen, Omeprazole, Cyclobenzaprine, Amitriptyline, psychiatric services, Mirtazapine, Trazodone, Gabapentin, Naproxen and LidoPro topical. The left shoulder MRI, EMG/NCS (electrodiagnostic studies and nerve conduction studies) of the upper extremities were normal. The IW completed treatment with TENS (transcutaneous electrical nerve stimulator) unit, chiropractic services and home exercise program. It was noted that the past chiropractic and acupuncture treatments did not help. The injured worker was diagnosed with status post left shoulder surgery, displacement of cervical intervertebral disc without myelopathy, cervical radiculitis, depression, anxiety and cervical neck strain/sprain. According to progress note of March 13, 2015, the injured workers chief complaint was back, left shoulder and neck pain. The injured worker rated the pain 8 out of 10; 0 being no pain and 10 being the worse pain. The left shoulder pain radiates into the left hand with tingling. The cervical neck MRI dated 4/11/2014 showed multilevel facet arthropathy and slight neuroforaminal stenosis. The lumbar spine pain was triggered by range of motion movements. The low back pain radiated into both lower extremities, more into the big toes with paresthesia. There was weakness noted in the lower extremities. The lumbar spine MRI was reported as normal. The treatment plan included lumbar support, cervical pillow, massage therapy, clearance for C5-C6 and C6-C7 epidurals and functional capacity evaluation. The current pain medications listed are fenoprofen and omeprazole.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

DME Lumbar support: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar Supports.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.23.5 Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Low Back, DME.

Decision rationale: The CA MTUS and the ODG guidelines recommend that DME can be utilized for the management of chronic musculoskeletal pain to improve mobility, physical function and pain relief that would not otherwise be possible without the DME. The records did not show subjective and objective findings of severe functional limitation that require continual use of lumbar support. The guidelines indicate that the beneficial effect of lumbar support is limited to the acute and post injury period. The criteria for the use of DME lumbar support was not medically necessary.

Cervical Pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Pillow.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.21. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Neck and Upper Back, DME.

Decision rationale: The CA MTUS and the ODG guidelines recommend that DME can be utilized for the management of chronic musculoskeletal pain to improve mobility, physical function and pain relief that would not otherwise be possible without the DME. The records did not show subjective and objective findings of severe functional limitation with the use of standard pillows. The guidelines did not indicate that there are beneficial effects with the use of cervical pillow in the absence of neck positional deformity outside the acute and post injury period. The criteria for the use of DME cervical pillow support was not medically necessary.

Massage x 6 for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211, Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Shoulder.

Decision rationale: The CA MTUS and the ODG guidelines recommend that physical treatments can be utilized for the management of exacerbation of musculoskeletal pain. The use of physical treatments can result in pain relief, reduction in medication utilization and functional restoration. The records indicate that there was no significant beneficial effect following past PT, chiropractic treatments and other physical treatment modalities. The guidelines noted that patients with significant psychosomatic symptoms report decreased efficacy and limited beneficial effects following interventional procedures, surgery and physical treatments. The criteria for the use of Massage X 6 for the left shoulder was not medically necessary.

PM&R for epidurals at C5-C6 and C6-C7: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Office Visits.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.23.1 Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Neck and Upper Back.

Decision rationale: The CA MTUS and the ODG guidelines recommend that epidural steroid injections can be utilized for the treatment of cervical radiculopathy when conservative treatments with medications and PT have failed. The records did not show objective, radiological or EMG/NCS consistent with a diagnosis of cervical radiculopathy. The guidelines indicate that there is decreased efficacy and beneficial effects to interventional pain procedures in patients with significant psychosomatic disorders. The criteria for PM&R epidural steroid injections at C5-C6 and C6-C7 was not medically necessary.

FCE (functional capacity evaluation): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Office Visits.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21, 81, 137. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

Decision rationale: The CA MTUS and the ODG guidelines recommend that Functional Capacity Evaluation can be utilized for determination of ability of the injured worker for return to work. The records did not show that the patient had completed active treatment programs. There are subjective and objective findings that the physical and psychosomatic symptoms had not resolved. The records did not show that the patient is on an active return to work program. The criteria for Functional Capacity Evaluation (FCE) was not medically necessary.

Ultrasound x 6 for the left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Ultrasound.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Shoulder.

Decision rationale: The CA MTUS and the ODG guidelines recommend that physical treatments can be utilized for the management of exacerbation of musculoskeletal pain. The use of physical treatments can result in pain relief, reduction in medications utilization and functional restoration. The records indicate that there was no significant beneficial effect following past PT, chiropractic treatments and other physical treatment modalities. The guidelines noted that patients with significant psychosomatic symptoms report decreased efficacy and limited beneficial effects following interventional procedures, surgery and physical treatments. The criteria for the use of Ultrasound X 6 for the left shoulder was not medically necessary.